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Inappropriate hospitalisations, aggressive treatments, and insufficient deprescribing: the medicalisation of death from natural causes

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Program Objectives

- To generate evidence for **extent of overtreatment** of older people (60+ years) **in hospitals and**
- To identify its **causes** & possible **solutions**

Article

Non-beneficial treatments in hospital at the end of life: a systematic review on extent of the problem

38 studies in 10 countries

M CARDONA-MORRELL¹, JCH KIM², RM TURNER³, M ANSTEY⁴,
IA MITCHELL⁵, and K HILLMAN^{1,6}

- 1 in 3 dying older patients receive NBT
- widespread low-value care practice in hospitals (from imaging to resuscitation)
- ICU admission was 10% (95% CI 0–33%)
- Chemotherapy in the last 6 weeks of life was 33% (95% CI 24–41%)



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European Journal of Internal Medicine

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Review Article

What is inappropriate hospital use for elderly people near the end of life? A systematic review



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ABSTRACT


Background: Older people with advance chronic illness use hospital services repeatedly near the end of life. Some of these hospitalizations are considered inappropriate.

Aim: To investigate extent and causes of *inappropriate* hospital admission among older patients near the end of life.

16 non-RCTs in 8 countries

- wide variation (from 1.7% to 67.0%)
- clinically inappropriate decision to admit for ambulatory-sensitive conditions
- too late to benefit (up to 35%)
- socially-driven admissions due to lack of community services (up to 10.5%)

Evidence still insufficient that advance care documentation leads to engagement of healthcare professionals in end-of-life discussions: A systematic review

Palliative Medicine
2016, Vol. 30(9) 807–824
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Ebony Lewis¹, Magnolia Cardona-Morrell¹, Kok Y Ong²,
Steven A Trankle² and Ken Hillman^{1,3}

24 qualitative or mixed methods studies from 10 countries

Abstract

Background: Administration of non-beneficial life-sustaining treatments in terminal elderly patients still occurs due to lack of knowledge of patient's wishes or delayed physician–family communications on preference.

Aim: To determine whether advance care documentation encourages healthcare professional's timely engagement in end-of-life discussions.

Design: Systematic review of the English language articles published from January 2000 to April 2015.

Data sources: EMBASE, MEDLINE, EBM REVIEWS, PsycINFO, CINAHL and Cochrane Library and manual searches of reference lists.

Results: A total of 24 eligible articles from 10 countries including 23,914 subjects met the inclusion criteria, mostly using qualitative or mixed methods, with the exception of two cohort studies. The influence of advance care documentation on initiation of end-of-life discussions was predominantly based on perceptions, attitudes, beliefs and personal experience rather than on standard replicable measures of effectiveness in triggering the discussion. While health professionals reported positive perceptions of the use of advance care documentations (18/24 studies), actual evidence of their engagement in end-of-life discussions or confidence gained from accessing previously formulated wishes in advance care documentations was not generally available.

Conclusion: Perceived effectiveness of advance care documentation in encouraging end-of-life discussions appears to be high but is mostly derived from low-level evidence studies. This may indicate a willingness and openness of patients, surrogates and staff to perceive advance directives as an instrument to improve communication, rather than actual evidence of timeliness or effectiveness

- clinician and patient perceived effectiveness of advance care documents in triggering discussions on withholding/withdrawing Rx.
- However, no quantifiable data could demonstrate actual effectiveness.

Systematic review

1. * Review title.

Give the working title of the review, for example the one used for obtaining funding. Ideally the title should

Effective interventions for sustainable deprescribing of hospitalized older patients near the end of life: systematic review to inform reduction of low-value care practices (Protocol)

Effective interventions for sustainable deprescribing of hospitalized older patients near end of life: systematic review to inform reduction of low-value care practices (Protocol)

2. Original language title.

For reviews in languages other than English, this field should be used to enter the title in the language of the review. This will be displayed together with the English language title.

3. * Anticipated or actual start date.

Give the date when the systematic review commenced, or is expected to commence.

27/02/2019

4. * Anticipated completion date.

Give the date by which the review is expected to be completed.

28/02/2020

568 potentially eligible studies → 121 full text → 1 EOL focus.

- Needed operational definition of end-of-life to identify 5 additional RCTs
- Scarce data on sustainability

Factors contributing to overtreatment at EOL

- Available technology for life-sustaining treatments
- Family pressure to 'do everything'
- Disagreement among clinical treating teams
- Infrequent medication reviews
- Shortage of community support services
- Low uptake of advance care planning
- Lack of recognition of dying trajectory
- Prognostic uncertainty delays discussions



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Identifying 'dying' and enhancing prognostic certainty

Review



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Development of a tool for defining and identifying the dying patient in hospital: Criteria for Screening and Triaging to Appropriate alternative care (CriSTAL)

Magnolia Cardona-Morrell,¹ Ken Hillman²

► Additional material is published online only. To view please visit the journal online (<http://dx.doi.org/10.1136/bmjspcare-2014-000770>).

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ABSTRACT

Objective To develop a screening tool to identify elderly patients at the end of life and quantify the risk of death in hospital or soon after discharge for to minimise prognostic uncertainty and avoid potentially harmful and futile treatments.

Design Narrative literature review of definitions, tools and measurements that could be combined into a screening tool based on routinely available or obtainable data at the point of care to identify elderly patients who are unavoidably dying at the time of admission or at risk of dying during hospitalisation.

BACKGROUND

The natural progression of chronic disease involves periods of apparent remission interspersed by exacerbations and, in the year leading to death, multiple hospitalisations.¹ Some indicators of poor prognosis can suggest a patient is nearing the *end of life*,² and have been found useful for initiating discussions with families regarding pre-emptive care planning.¹ Yet there is uncertainty of the time, frequency and duration of the next episode of decompensation as well as the ultimate prognosis

Potential
Solutions to
minimize
overtreatment
near EOL

Training clinicians in prognostication

Communications training to break bad news

Multicomponent interventions: proactive
deprescribing & proactive palliative care

Expand community-based EOL services

Reimbursement for comprehensive risk of
death assessment and discussions

Educational campaigns to reduce public
demand for 'everything'

Take-home messages

- Normalise death talk at all ages
- Re-embrace the concept of death from old age and irreversible chronic illness → part of the life cycle.
- A certain level of aggressive treatment is inevitable and sometimes justifiable
- Efforts to identify avoidable overtreatment to
 - Reduce low value care
 - Minimise unsustainable healthcare costs
 - Prevent unnecessary suffering

Questions?

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